Hills & Dales General Hospital

Patient Financial Profile

The information on this form is requested so that Hills and Dales can give full consideration to a request for charity care. The information will be kept confidential and will not be used for any other purpose. Please submit copy of last paycheck, current Federal Income Tax Return and copy of Social Services Rejection (Medicaid Denial) for Date of Service.

PATIENT INFORMATION

Patient's Name _____ Social Security # _____

Date (s) of Service _____

Address _____ Telephone # _____

Name of Responsible Party _____ Relationship to Patient _____

Employer _____ Address _____

If Unemployed, How Long? _____

Spouse's Employer _____ Address _____

If Unemployed, How Long? _____

LIST ALL FAMILY MEMBERS IN YOUR HOUSEHOLD

_____ _____ _____

_____ _____ _____

_____ _____ _____

MONTHLY HOUSEHOLD INCOME & SOURCES

	Patient	Spouse	Responsible Party	Other(s)
Monthly Salary (Gross)				
Public Assistance Benefits				
Social Security Benefits				
Workmen's Compensation				
Child Support				
Other (Alimony, ect.)				

** Need Proof of Information Listed Above, Please Include Copy

Total Family Income $ _____

I certify that the information submitted herein is true and accurate to the best of my knowledge. I understand that this application is made so that Hills and Dales General Hospital can judge my eligibility for a discount based on the financial assistance sliding scale program criteria. If any information I have given proves to be untrue, I understand that the hospital or other operating entity may re-evalutate my financial status and take whatever action becomes appropriate. All information provided is subject to verification and may include a credit check.

Date of Request _____ Applications Signature _____

WHEN INDICATED, PLEASE COMPLETE THE FOLLOWING:

List unusual circumstances or monthly expenses that may affect your current financial status.

MONTHLY EXPENSES:

Housing: Rent Own Balance Owed $ _____
Financed By _____

Monthly Payment $ _____

Property Taxes $ _____ (if paid separate from house payment)

Home Insurance $ _____ (if paid separate from house payment)

Auto Payment $ _____

Gas/Transportation $ _____

Food $ _____

Utilities $ _____

Insurance $ _____

Total Expenses: $ _____

Monthly Medical Supplies

Monthly Expenses:

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

Monthly Pharmacy (Medications):

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
Total Monthly Medical Supply and Pharmacy Expenses:	$ _____

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Checking Account: Financial Institution _____ Balance $ _____

Savings Account: Financial Institution _____ Balance $ _____

Certificate of Deposit (CD): $ _____ IRA $ _____ 401K: $ _____

** Please Include a Copy of Last Bank Statement